Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1214SNF	A. BUILDING _____ B. WING _____	C 07/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VEGAS VALLEY REHABILITATION HOSPITAL	2945 CASA VEGAS STREET LAS VEGAS, NV 89109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 7/13/09 and finalized on 7/23/09, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00022013 was substantiated with a deficiency cited. (See Tag Z 230) Complaint #NV00022114 was substantiated with a deficiency cited. (See Tag Z 310) Complaint #NV00022153 was substantiated with a deficiencies cited. (See Tag Z 310) Complaint #NV00021782 was partially substantiated with no deficiencies cited. Complaint #NV00022185 was unsubstantiated. Complaint #NV00022492 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1214SNF	A. BUILDING _____ B. WING _____	C 07/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VEGAS VALLEY REHABILITATION HOSPITAL	2945 CASA VEGAS STREET LAS VEGAS, NV 89109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 1 that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure blood was drawn for lab work on the morning of 2/24/09 for 1 of 7 patients (Patients #1). Severity 2 Scope 1	Z230		
Z310 SS=D	NAC449.74493 Notification of Changes or Condition 1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accident and may require treatment from a physician; (b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life; (c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharged from the facility; (e) The patient will be assigned to another room or assigned a new roommate; or (f) There is any change in federal or state law that affects the rights of the patient. This Regulation is not met as evidenced by:	Z310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1214SNF	A. BUILDING _____ B. WING _____	C 07/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VEGAS VALLEY REHABILITATION HOSPITAL	2945 CASA VEGAS STREET LAS VEGAS, NV 89109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z310	Continued From page 2 Based on record review and interview the facility failed to immediately notify the resident's family of a fall for 2 of 7 residents (Residents #3 and #5). Resident #3 fell on 5/17/09. The family was not notified. Resident #5 fell on 4/23/08. The family was notified 4/24/08. Severity 2 Scope 1	Z310		